



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 04741

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Sara Dennis
Deceased:	Michelle Bengner
Date of birth:	23 April 1974
Date of death:	12 August 2025
Cause of death:	1a: Sepsis complicating aspiration pneumonia in the setting of epilepsy, Cornelia de Lange syndrome and other medical comorbidities
Place of death:	Sunshine Hospital 176 Furlong Road St Albans Victoria 3021
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 12 August 2025, Michelle Bengner was 51 years old when she died at Sunshine Hospital.
2. At the time of her death, Michelle resided at a Specialist Disability Accommodation (SDA) dwelling in St Albans, enrolled under the National Disability Insurance Scheme (NDIS). Michelle received funded daily independent living support which was provided by disability service provider, Scope (Aust) Limited.
3. Michelle's medical history included Cornelia de Lange syndrome (diagnosed at birth) with severe intellectual disability, and gastro-oesophageal reflux disease, epilepsy and a previous hip replacement.
4. Michelle required one-to-one support and was fully dependent for all her activities of daily living. She was non-verbal but communicated with gestures, vocalisations, touch and objects. She was ambulant but was unsteady on her feet, and used a wheelchair in the community.
5. Michelle had lived in her SDA dwelling since 2008 and was well known to her carers, including Vicki Hearn, who had cared for her since 2011. She enjoyed sensory activities and her favourite place was the sensory room at her home, where she spent time watching the lights and displays and listening to music. She also adored being out in the community, particularly when she could enjoy food, coffee or a chai latte.
6. Vicki remembers Michelle as "*the most delightful human imaginable*" and noted that her absence left a huge void at her residence.

THE CORONIAL INVESTIGATION

7. Michelle's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as she was a 'person placed in custody or care' within the meaning of the Act, as a person with disability who received funded daily independent living support and resided in an SDA enrolled dwelling immediately prior to her death.¹ This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The

¹ This class of person is prescribed as a 'person placed in custody or care' under the *Coroners Regulations 2019* (Vic), r 7(1)(d).

coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

8. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.
9. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.
10. Coroner Audrey Jamieson (as her Honour then was) originally held carriage of this investigation prior to her retirement in April 2026. I assumed carriage of this investigation on 27 April 2026.
11. This finding draws on the totality of the coronial investigation into the death of Michelle Benger including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.²

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

12. On 4 August 2025, Michelle vomited and had a reduced appetite for the remainder of the day.
13. At around 9:20am on 5 August 2025, care staff found Michelle unresponsive. She was subsequently conveyed by ambulance to the Sunshine Hospital Emergency Department, where the initial impression was of a reduced conscious state with hypoxia and hypotension, from likely aspiration pneumonia. She was commenced on IV fluids and antibiotics.

² Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

14. Michelle was reviewed by an Intensive Care Unit (**ICU**) registrar who formed the impression that she was in hypovolaemic and septic shock from pneumonia. Michelle was determined to not be suitable for ICU care due to her premorbid levels of function, and her care was continued on the ward. IV fluids and antibiotics were continued, as well as anti-seizure medication.
15. Despite maximal medical intervention, Michelle's condition continued to decline. On 11 August 2025, following discussion with her carers, she was transitioned to palliative management. IV therapies were ceased and she received comfort care.
16. Michelle died peacefully on 12 August 2025, at 3:02pm.

Identity of the deceased

17. On 12 August 2025, Michelle Bengener, born 23 April 1974, visually identified by support worker Vicki Hearn, who completed a Statement of Identification.
18. Identity is not in dispute and requires no further investigation.

Medical cause of death

19. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of Michelle Bengener on 15 August 2025 and provided a written report of her findings dated 7 January 2026.
20. The external examination and a post-mortem CT scan showed findings consistent with the clinical history.
21. Dr Francis provided an opinion that the death was due to natural causes and ascribed the medical cause of death as *I(a) Sepsis complicating aspiration pneumonia in the setting of epilepsy, Cornelia de Lange syndrome and other medical comorbidities*.
22. I accept Dr Francis' opinion as to the cause of death.

FINDINGS AND CONCLUSION

23. Pursuant to section 67(1) of the *Coroners Act 2008* (Vic) I make the following findings:
 - a) the identity of the deceased was Michelle Bengener, born 23 April 1974;

- b) the death occurred on 12 August 2025 at Sunshine Hospital, 176 Furlong Road, St Albans, Victoria 3021;
 - c) the cause of Michelle's death was sepsis complicating aspiration pneumonia in the setting of epilepsy, Cornelia de Lange syndrome and other medical comorbidities; and
 - d) the death occurred in the circumstances described above.
24. The available evidence does not support a finding that there was any want of clinical management or care on the part of the disability service provider, or clinical staff at Sunshine Hospital, that caused or contributed to Michelle's death.
25. Having considered all the available evidence, I find that Michelle's death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into her death and to finalise the investigation of Michelle's death in chambers.

I convey my sincere condolences to Michelle's family, friends and carers for their loss. I acknowledge the dedicated and genuine care provided by her carers, and in particular Vicki Hearn, who had cared for Michelle for many years and in doing so developed a close connection with her.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Eleanor Bengier, Senior Next of Kin

Scope (Aust) Limited

Western Health

Senior Constable Dario Sorbello, Coronial Investigator

Signature:



Coroner Sara Dennis

Date: 30 September 2026

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.
